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2000 STATE OF ILLINOIS DEPARTMENT OF PUBLIC AID FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES (FISCAL YEAR 2000)

IMPORTANT NOTICE

THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I.	IDPH Facility ID Number: 0013	920		II. CERTIFICAT	ON BY AUTHORIZED FACILITY OFFICER
	Facility Name: St Paul's Home Address: P.O. Box 347 1021 West "E" St. Number County: St. Clair	Belleville City	62222 Zip Code	State of Illinois and certify to the are true, accura applicable inst	ned the contents of the accompanying report to the for the period from 01/01/2000 to 12/31/2000 to 1
	Telephone Number: 618-233-2095 IDPA ID Number: 37-0681517 001	Fax # 618-233-2109		Intentional r	information of which preparer has any knowledge. nisrepresentation or falsification of any information ort may be punishable by fine and/or imprisonment.
	Date of Initial License for Current Owners: Type of Ownership:	unable to locate		Officer or Administrator of Provider	(Date) Arthur H. Peters
	X VOLUNTARY, NON-PROFIT X Charitable Corp. Trust	PROPRIETARY Individual Partnership	GOVERNMENTAL State County	(Title)	President/Administrator
	IRS Exemption Code 501 C (3)	Corporation "Sub-S" Corp. Limited Liability Co. Trust Other	Other	Paid (Print in the preparer and Time in the preparer and Time in the preparer	(Date) Name le) Name ress)
	In the event there are further questions about t Name: Shirley Saia	his report, please contact: Telephone Number: 618-233-2	095	(1 егері	MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630

STATE OF ILLINOIS Page 2

Faci	ity Name & ID Numbe	er St Paul's Hor	ne				# 0013920 Report Period Beginning: 01/01/2000 Ending: 12/31/20	100
	III. STATISTICAI	L DATA					D. How many bed-hold days during this year were paid by Public Aid?	
	A. Licensure/co	ertification level(s) of	f care; enter number	of beds/bed days,			(Do not include bed-hold days in Section B.)	
	(must agree v	with license). Date of	change in licensed b	oeds				
				_			E. List all services provided by your facility for non-patients.	
	1	2		3	4		(E.g., day care, "meals on wheels", outpatient therapy)	
							None	
	Beds at				Licensed			
	Beginning of	Licensu	re	Beds at End of	Bed Days During		F. Does the facility maintain a daily midnight census? yes	
	Report Period	Level of	Care	Report Period	Report Period			
				1			G. Do pages 3 & 4 include expenses for services or	
1		Skilled (SNI	F)			1	investments not directly related to patient care?	
2		Skilled Pedi	atric (SNF/PED)			2	YES NO X	
3	113	Intermediat	e (ICF)	113	41,358	3		
4		Intermediat	e/DD			4	H. Does the BALANCE SHEET (page 17) reflect any non-care assets?	
5	62	Sheltered C	are (SC)	62	22,692	5	YES X NO	
6		ICF/DD 16	or Less			6		
_					- 1 0 - 0		I. On what date did you start providing long term care at this location?	
7	175	TOTALS		175	64,050	7	Date started 1926	
	D. Comerce For	4h a andina nanant nan	a				J. Was the facility purchased or leased after January 1, 1978? YES Date NO X	
	B. Census-ror	the entire report per	3		5		YES Date NO X	
	1	_	•	4 1 D.: C C	-		V. W. d. C. The color of C. A.C. M. P	
	Level of Care	Patient Days Public Aid	by Level of Care an	d Primary Source of	Payment	-	K. Was the facility certified for Medicare during the reporting year? YES NO X If YES, enter number	
		Recipient	Private Pay	Other	Total		of beds certified and days of care provided	
8	SNF	Recipient	1 Hvate 1 ay	Other	Total	8	and days of care provided	—
9	SNF/PED					9	Medicare Intermediary	
10	ICF	20,878	18,507		39,385	10	Medicare interinedially	_
11	ICF/DD	20,070	10,507		37,303	11	IV. ACCOUNTING BASIS	
12	SC	2,840	9,394		12,234	12	MODIFIED	
	DD 16 OR LESS	7-17	- /		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	13	ACCRUAL X CASH* CASH*	
	TOTAL C	22.710	27.004		#1 c10		X C A A A A A A A A A A A A A A A A A A	
14	TOTALS	23,718	27,901	1	51,619	14	Is your fiscal year identical to your tax year? YES X NO	
	C. Percent Occ	cupancy. (Column 5,	line 14 divided by to	tal licensed			Tax Year: 12/31/2000 Fiscal Year:	
		line 7, column 4.)	80.59%				* All facilities other than governmental must report on the accrual basis.	
				_				

STATE OF ILLINOIS Page 3 12/31/2000 Facility Name & ID Number St Paul's Home # 0013920 **Report Period Beginning:** 01/01/2000 Ending:

	racinty Name & ID Number	St raul's nome			π_	0013920	Report Periou	Deginning.	01/01/2000	Enging:	12/31/2000	_
_	V. COST CENTER EXPENSES (through	hout the report,	please round to	the nearest do	llar)	Reclass-	Reclassified	Adinat	Adinated	EOD OHE	USE ONLY	
	O		osts Per Genera	-	T-4-1			Adjust-	Adjusted	rok onr	USE ONL I	
	Operating Expenses	Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total	0	10	
	A. General Services	1 2(0.724	22 206	3	4	5	6	7	8	9	10	<u> </u>
1	Dietary	268,734	22,296	22,828	313,858		313,858		313,858			1
2	Food Purchase		241,789		241,789		241,789		241,789			2
3	Housekeeping	229,168	40,058		269,226		269,226		269,226			3
4	Laundry	119,486	24,684		144,170		144,170		144,170			4
5	Heat and Other Utilities			186,209	186,209		186,209		186,209			5
6	Maintenance	78,734	36,292	34,125	149,151	924	150,075		150,075			6
7	Other (specify):* Security	10,314			10,314		10,314		10,314			7
8	TOTAL General Services	706,436	365,119	243,162	1,314,717	924	1,315,641		1,315,641			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	1,384,682	19,661	121,678	1,526,021		1,526,021		1,526,021			10
10a	Therapy	65,748		7,960	73,708		73,708		73,708			10a
11	Activities	57,637	4,863	3,222	65,722	314	66,036		66,036			11
12	Social Services	51,721	59	779	52,559		52,559		52,559			12
13	Nurse Aide Training	ĺ			,		,					13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,559,788	24,583	139,639	1,724,010	314	1,724,324		1,724,324			16
	C. General Administration			, i								
17	Administrative	74,608			74,608		74,608		74,608			17
18	Directors Fees				·							18
19	Professional Services			36,842	36,842		36,842		36,842			19
20	Dues, Fees, Subscriptions & Promotions			26,073	26,073		26,073	(5,120)	20,953			20
21	Clerical & General Office Expenses	194,747	26,820	15,259	236,826		236,826	(-) -)	236,826			21
22	Employee Benefits & Payroll Taxes	,		602,914	602,914		602,914		602,914			22
23	Inservice Training & Education			,	,		/		,			23
24	Travel and Seminar			5,191	5,191		5,191		5,191			24
25	Other Admin. Staff Transportation			-,	-,-/-		-,-/-		-,-/-			25
26	Insurance-Prop.Liab.Malpractice			38,973	38,973		38,973		38,973			26
	Other (specify):*			19,187	19,187	(1,238)	17,949	(15,766)	2,183			27
28	TOTAL General Administration	269,355	26,820	744,439	1,040,614	(1,238)	1,039,376	(20,886)	1,018,490			28
	TOTAL Operating Expense	, i	,	ŕ	, ,	(-,=00)						
29	(sum of lines 8, 16 & 28) *Attach a schedule if more than one type	2,535,579	416,522	1,127,240	4,079,341		4,079,341	(20,886)	4,058,455			29

**Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

#0013920

Report Period Beginning:

01/01/2000 Ending:

Page 4 12/31/2000

V. COST CENTER EXPENSES (continued)

			Cost Per Gener	al Ledger		Reclass-	Reclassified		Adjusted	FOR OHF	USE ONLY	
	Capital Expense	Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total			
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			192,792	192,792		192,792		192,792			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			68,011	68,011		68,011		68,011			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			260,803	260,803		260,803		260,803			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			6,085	6,085		6,085		6,085			38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			62,038	62,038		62,038		62,038			42
43	Other (specify):*	7,402			7,402		7,402		7,402			43
44	TOTAL Special Cost Centers	7,402		68,123	75,525		75,525		75,525	•		44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	2,542,981	416,522	1,456,166	4,415,669		4,415,669	(20,886)	4,394,783			45

^{*}Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

39

40 Gift and Coffee Shops

46 Other-Attach Schedule

47 TOTAL (C): (sum of lines 38-46)

43 Prescription Drugs

Page 5

0013920 **Report Period Beginning:** 01/01/2000

12/31/2000

Ending:

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	Tii Coluiiii	1 2 below, reference t	2		iai cos
		1	Refer-	OHF USE	
	NON-ALLOWABLE EXPENSES	Amount	ence	ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(11,0	92) 27		24
25	Fund Raising, Advertising and Promotional	(2,1	56) 20		25
	Income Taxes and Illinois Personal				
26					26
	Nurse Aide Training for Non-Employees				27
	Yellow Page Advertising	(2,8			28
	Other-Attach Schedule	(4,7			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (20,8	86)	\$	30

	OHF USE ONL	Y				
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below. (See instructions.)

1	<u> </u>	
Amount	Reference	
		31
		32
		33

46

47

31	Non-Paid Workers-Attach Schedule*	\$	31
32	Donated Goods-Attach Schedule*		32
	Amortization of Organization &		
33	Pre-Operating Expense		33
	Adjustments for Related Organization		
34	Costs (Schedule VII)		34
	Other- Attach Schedule		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$	36
	(sum of SUBTOTALS		
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (20,886)	37

^{*}These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.) 2

Yes No Amount Reference 38 Medically Necessary Transport. X \$ 38 39 40 X 41 Barber and Beauty Shops 41 X 42 Laboratory and Radiology X 42 43 44 Exceptional Care Program 44 X 45 Other-Attach Schedule 45

Page 5A

1 Dues to 2 Newslet 3 "Compli	-ALLOWABLE EXPENSES civic organization	Amount S (120)	Reference 20	_
2 Newslet 3 "Compl:				1
3 "Compli	ter expense	(4,284) (258)	27 27	2
	ance" ad	(258)	27	3
4 Miscella 5 Donatio	neous sundry items	(82)	27 27	5
6	is .	(30)	27	6
7				7
8				8
9				9
10 11				10 11
12				12
13				13
14				14
15				15
16 17				16 17
18				18
19				19
20				20
21				21
22				22
24				23
25				25
26				26
27 28				27
28				28
29 30				29 30
31				31
32				32
33				33
34				34
35				35
36 37				36 37
38				38
39				39
40				40
41				41
42				42
43				43
45				45
46				46
47				47
48				48
49				49
50 51				50 51
52				52
53				53
54				54
55 56				55 56
57				57
58				58
59 60				59 60
60				60
62				62
63				63
64				64
65 66				65 66
67				67
68				68
69				69
70 71				70 71
72				72
73				73
74				74
75 76				75 76
77				77
78 79				78 79
79				79
80				80 81
81 82				81
83				83
84				84
85 86				85 86
86				86
88				88
89				89
90 Total	<u> </u>	(4,794)		90

Summary A 01/01/2000 Ending: 12/31/2000 Facility Name & ID Number St Paul's Home # 0013920 Report Period Beginning:

	SUMMARY OF PACES 5 54 6 6		CE CE CC CE	I AND CI		#	0013920	Report Ferio	a Beginning.		01/01/2000	Enaing:	12/31/2000	
	SUMMARY OF PAGES 5, 5A, 6, 6A	1, 6B, 6C, 6D, 6	DE, 0F, 0G, 0H	I AND 61				1	I		I		CYD CO CA DX	
	0 1 7	D. CTC	D. CT	D. C.	D. CT	D. C.	D . CT	D. C.	D. CT	D. CT	D. CT	D. C.	SUMMARY	
	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6Н	61	(to Sch V, col.	7)
1	Dietary	0	0	0	0	0	0		0	0	0	0	ű	1
2	Food Purchase	0	0	0	0	0	0		0	0	0	0	ų.	2
3	Housekeeping	0	0	0	0	0	0		0	0	0	0		3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	·	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0		5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0		6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration	Ů	Ü		Ů	Ü	,	ű	Ü	Ü	Ü	, and the second		10
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0		18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(5,120)	0	0	0	0	0	0	0	0	0	0		
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0		21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0		22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0		23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	·	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	ű	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0		0	0	0	0		26
27	Other (specify):*	(15,766)	0	0	0	0	0		0	0	0	0		
-		` ' '		0	0	-	0			·		-	· , , ,	
28	TOTAL General Administration	(20,886)	0	0	U	0	U	0	0	0	0	0	(20,886)	28
	TOTAL Operating Expense											1		
29	(sum of lines 8,16 & 28)	(20,886)	0	0	0	0	0	0	0	0	0	0	(20,886)	29

Facility Name & ID Number St Paul's Home # 0013920 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

													SUMMARY	
	Capital Expense	PAGES	PAGE	PAGE	PAGE	TOTALS								
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6 G	6H	6 I	(to Sch V, col.	.7)
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(20,886)	0	0	0	0	0	0	0	0	0	0	(20,886)	45

0013920

Report Period Beginning:

12/31/2000

VII. RELATED PARTIES

A Finter below the names of ALL owners and related organizations (narties) as defined in the instructions. Attach an additional schedule if necessary

A. Enter below the names of ALL C	Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule in necessary.										
1		2			3						
OWNERS		RELATED NURSING HOMES					OTHER RELA	ATED BUSINESS ENTIT	IES		
Name	Ownership %	Name		City		Name		City	Type of Business		
See attached schedule											

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES X NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
						Percent	Operating Cost		
Sch	edule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization	ı
						Ownership	Organization	Costs (7 minus 4)	
1	V			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

^{*} Total must agree with the amount recorded on line 34 of Schedule VI.

Page 7

Ending:

Facility Name & ID Number VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

St Paul's Home

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5		6	7		8	
						Average Hou	ırs Per Work				
					Compensation	Week Dev	oted to this	Compensation Included		Schedule V.	
					Received		l % of Total	in Costs		Line &	
				Ownership	From Other	Work	Week	Reportin	g Period**	Column	
	Name	Title	Function	Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

^{*} If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

^{**} This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME. ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

STATE OF ILLINOIS Page 8

Facility Name & ID Number St Paul's Home	# 0013920	Report Period Beginning:	01/01/2000	Ending:	2/31/2000	
VIII. ALLOCATION OF INDIRECT COSTS						
		Name of Related	l Organization			
A. Are there any costs included in this report which were derived from allocations of centr	al office	Street Address	_			
or parent organization costs? (See instructions.)	X	City / State / Zip	Code	_		
<u> </u>		Phone Number	()		
B. Show the allocation of costs below. If necessary, please attach worksheets.		Fax Number	()		

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary			
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocation	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1						\$	\$		\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11 12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

2 10 Reporting Monthly Maturity Interest Period Name of Lender Related** **Purpose of Loan Payment** Date Interest Date of **Amount of Note** Rate YES NO Required Original Note Balance (4 Digits) Expense A. Directly Facility Related Long-Term **Union Planters Bank** Real Estate Mortgage **\$5,636.00** | 12/13/96 | **\$** 653,108 \$ 12/13/01 0.1000 \$ 59,932 **Union Planters Bank** Real Estate Mortgage \$5,486.00 12/15/00 636,144 636,144 06/13/05 0.0875 2,982 2 3 3 4 5 Interest Income (1,354)5 **Working Capital** 6 Union Planters Bank X Provide operating funds 175,000 175,000 06/15/01 0.1000 3,913 6/15/00 7 St. Paul's Home Foundation X 1/18/00 63,500 63,500 01/18/01 0.0575 2,538 Provide operating funds 8 TOTAL Facility Related \$11,122.00 874,644 9 1,527,752 \$ 68,011 B. Non-Facility Related* 10 10 11 11 12 12 13 13 14 TOTAL Non-Facility Related 14 15 TOTALS (line 9+line14) 1,527,752 \$ 874,644 68,011 15

^{*} Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

^{**} If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number St Paul's Home

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Real Estate Tax accrual used on 1999 report.				s	Exempt	1	
2. Real Estate Taxes paid during the year: (Indicate	the tax year to which this payment applies. If payment cover	ers more than one year, de	ail below.)	\$		2	
3. Under or (over) accrual (line 2 minus line 1).				s	#VALUE!	3	
4. Real Estate Tax accrual used for 2000 report. (E	Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)						
**	h has NOT been included in professional fees or other gene opies of invoices to support the cost and a co			\$		5	
-	usly to calculate a payment rate. You must offset the full real estate tax cost plus one-half of any remaining refund. 19 Tax Year. (Attach a copy of the re	al estate tax appeal	board's decision.)	\$	Exempt	6	
7. Real Estate Tax expense reported on Schedule V	line 33. This should be a combination of lines 3 thru 6.			\$	#VALUE!		
Real Estate Tax History:						7	
						7	
Real Estate Tax Bill for Calendar Year:	19958		FOR OHF USE ONLY			7	
·	1995 8 1996 9 1997 10	13	FOR OHF USE ONLY FROM R. E. TAX STATEMENT FO	DR 1999	\$	13	
·	1996 9	13			s s		
·	1996 9 1997 10 1998 11		FROM R. E. TAX STATEMENT FO			1;	

NOTES:

- 1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
- If facility is a non-profit which pays real estate taxes, you must attach a denial of an
 application for real estate tax exemption unless the building is rented from a for-profit entity.
 This denial must be no more than four years old at the time the cost report is filed.

STATE	OFIL	LINOIC	

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Facility Name & ID Number St Paul's Home 0013920 Report Period Beginning: 01/01/2000 Ending: 12/31/2000 X. BUILDING AND GENERAL INFORMATION: 56,032 **B.** General Construction Type: **Brick Number of Stories** see attached Square Feet: Exterior Frame Does the Operating Entity? X (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization. (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.) X (a) Own the Equipment (c) Rent equipment from Completely Does the Operating Entity? (b) Rent equipment from a Related Organization. Unrelated Organization. (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.) List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable). St. Paul's Home for the Aged Retirement Community, independent living apartments, 62500 square feet, 53 apartments YES NO Does this cost report reflect any organization or pre-operating costs which are being amortized? If so, please complete the following: 1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized: 3. Current Period Amortization: 4. Dates Incurred: Nature of Costs: (Attach a complete schedule detailing the total amount of organization and pre-operating costs.) XI. OWNERSHIP COSTS: 2 3 Square Feet Year Acquired A. Land. Use Cost Resident use 178,000 1926 16,901

Land Improvements

#VALUE!

199:

5,310

22,211

Resident use

3 TOTALS

01/01/2000 Ending: Page 12 12/31/2000 Facility Name & ID Number St Paul's Home # 0013

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar. 0013920 Report Period Beginning:

	B. Building	g Depreciation-Including Fixed Equ	npment. (See instr	uctions.) Kouna	all numbers to near	rest donar.					
	1		2	3	4	5	6	7	8	9	\Box
		FOR OHF USE ONLY	Year	Year		Current Book	Life	Straight Line		Accumulated	
	Beds*		Acquired	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
4	30		1960	1960	\$ 166,566	\$	25	\$	\$	\$ 166,566	4
5	32		1957	1957	148,250	2,968	50	2,968		127,484	5
6	38		1962	1962	266,977	5,909	50	5,909		202,110	6
7	75		1971	1971	654,498	15,997	40	15,997		487,596	7
8			1981	1981	718,105	18,313	40	18,313		367,413	8
	Improve	ement Type**									
9		• • • • • • • • • • • • • • • • • • • •		1961	14,618		25			14,618	9
10				1963	594		25			594	10
11				1971	40,791		25			40,791	11
12				1973	1,471		25			1,471	12
13				1974	1,162		20			1,162	13
14				1975	7,723	55	25	55		7,723	14
15				1976	75,275	2,015	35	2,015		53,959	15
16				1977	13,703		10			13,703	16
17				1978	24,680		15			24,680	17
18				1979	454,801	15,932	30	15,932		326,295	18
19				1980	5,908		20			5,908	19
20				1982	44,406	1,866	10	1,866		38,483	20
21				1983	6,581		10			6,581	21
22				1984	8,251		10			8,251	22
23				1985	2,786	56	10	56		2,786	23
24				1986	17,208	691	20	691		9,881	24
25				1987	169,475	7,439	20	7,439		116,579	25
26				1989	38,131	2,542	15	2,542		29,233	26
27				1991	109,995	5,220	20	5,220		58,236	27
28				1992	54,380	3,866	10	3,866		36,451	28
29				1993	6,300	252	25	252		2,016	29
30				1994	45,495	3,119	15	3,119		21,123	30
	Danamad mariti-	a lat/aidamallaimmuuamanta		1995 1996	21,589	2,159 1,699	10	2,159 1,699		12,954 7,646	31
		g lot/sidewalk improvements ration and door installation		1996	19,616 38,379	2,009	15 20	2,009		9,955	32
		ation and door installation inistrative office area		1996	9,218	615	15	615		9,955 2,741	33 34
	Installation of fe			1996	4,099	410	10	410		2,741	35
				1990			10		6		
36	TOTAL (lines	4 thru 55)			\$ 3,191,031	\$ 93,132		\$ 93,132	3	\$ 2,207,039	36

^{*}Total beds on this schedule must agree with page 2.

^{**}Improvement type must be detailed in order for the cost report to be considered complete.

01/01/2000 Ending: Page 12A 12/31/2000 Facility Name & ID Number St Paul's Home # 0013

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar. 0013920 Report Period Beginning:

D. Dun	ding Depreciation-Including Fixed Equip	ment. (See instr	uctions.) Round	all numbers to near	rest dollar.					
1	FOR OUR WAR OVER	2	3	4	5	6	7	8	9	
	FOR OHF USE ONLY	Year	Year		Current Book	Life	Straight Line		Accumulated	
Beds*		Acquired	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
4				\$	\$		\$	\$	\$	4
5										5
6										6
7										7
8										8
Imp	rovement Type**									
9 Supplement	tal lighting for parking lot		1997	1,225	82	10	82		328	9
10 Asphalt dri	veway improvements		1997	11,065	1,362	10	1,362		4,767	10
11 Building for	r emergency generator		1997	33,000	1,000	33	1,000		4,000	11
	mprovements to Kohl Wing		1997	21,878	1,286	20	1,286		4,709	12
13 Installation	of fences		1997	1,823	182	10	182		637	13
14 Telephone a	alcove and construction of wall divider		1997	3,690	246	15	246		984	14
15 Internal cor	ridor doors		1997	4,118	412	10	412		1,648	15
16 Remodeling	/redecorating or resident rooms/areas		1997	29,198	2,920	10	2,920		11,680	16
	ramp/brackets for porch area		1998	1,121	224	5	224		560	17
18 Tuckpointing	ng/caulking of retaining wall		1998	2,500	313	8	313		782	18
19 Soffit/fascia	installation		1998	13,194	660	20	660		1,650	19
20 Wallcoverin	ng (Employee dining room and main corridor)	1998	2,765	277	10	277		831	20
21 Roof replac	ement (Kohl wing)		1998	31,078	2,179	10	2,179		5,448	21
	g of shower room (Kohl wing)		1998	3,836	384	10	384		960	22
	s (Ludwig wing)		1998	1,620	162	10	162		405	23
	ses' station renovation		1999	7,194	719	10	719		1,438	24
	repairs to Kohl wing		1999	1,988	199	10	199		398	25
	l and flooring replacements (Kohl wing)		1999	4,418	442	10	442		884	26
	vare for Ludwig front door		1999	527	106	5	106		158	27
28 Bartel wing			1999	5,034	503	10	503		755	28
	lomestic water line		1999	1,927	193	10	193		289	29
	ly lines for cooling tower		1999	592	59	10	59		89	30
31 Chapel roof			1999	3,025	302	10	302		465	31
	d linen room remodeling		2000	7,860	524	15	524		524	32
	ers for front entry and main corridor		2000	1,209	60	10	60		60	33
	nt of Bartel wing sewer line		2000	16,237	812	20	812		812	34
35				-						35
36 TOTAL (li	ines 4 thru 35)			\$ 212,122	\$ 15,608		\$ 15,608	\$	\$ 45,261	36

^{*}Total beds on this schedule must agree with page 2.

^{**}Improvement type must be detailed in order for the cost report to be considered complete.

STA	TE	OE	ш	IIN	\mathbf{O}

		9	STATE OF ILLINOIS	;			Page 13
Facility Name & ID Number	St Paul's Home	#	0013920	Report Period Beginning:	01/01/2000	Ending:	12/31/2000

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of	1		Current Book	Straight Line	4	4 Component		
	Equipment	Cost		Depreciation 2	Depreciation 3	Adjustments	Life 5	Depreciation	6
37	Purchased in Prior Years	\$ 896,023	S	§ 73,950	\$ 73,950	\$		\$ 462,320	37
38	Current Year Purchases	13,448		1,403	1,403			1,403	38
39	Fully Depreciated Assets	527,339		6,176	6,176			527,339	39
40					·	•			40
41	TOTALS	\$ 1,436,810	9	81,529	\$ 81,529	\$		\$ 991,062	41

D. Vehicle Depreciation (See instructions.)*

	Di temere Depreemeron (See	moti actionsi)									
	1	Model, Make	Year	4	Current Book	Straight Line	7	Life in	Accumulated		
	Use	and Year 2	Acquired 3	Cost	Depreciation 5	Depreciation 6	Adjustments	Years 8	Depreciation 9		
42	2 Van/improvements	Ford 1985	1985	\$ 26,794	\$	\$	\$		\$ 26,794	42	
43	3 Van	Ford 1992	1995	11,560	1,156	1,156		5	11,560	43	
4	Van improvements	Ford 1992 (lift)	1996	3,595	719	719		5	3,595	44	
45	Van improvements	Ford 1985	1997	3,240	648	648		5	2,268	45	
40	TOTALS			\$ 45,189	\$ 2,523	\$ 2,523	\$		\$ 44,217	46	

E. Summary of Care-Related Assets

	E. Summary of Care-Related Assets	1	2		
		Reference	Amount		1
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ 4,907,363	47	J
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 192,792	48	1
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 192,792	49	**
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	\$	50]
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 3,287,579	51	Ī

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1	2	Current Book	Accumulated	
	Description & Year Acquired	Cost	Depreciation 3	Depreciation 4	
52		\$	\$	\$	52
53					53
54					54
55					55
56					56
57	TOTALS	\$	\$	\$	57

G. Construction-in-Progress

	Description	Cos	t	
58	Parking Lot improvements	\$	955	58
59				59
60				60
61		\$	955	61

Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

This must agree with Schedule V line 30, column 8.

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Faci	lity Name & II) Number	St Paul's Home			# 0013920	Repor	rt Period Beginning:	01/01/2000	Ending:	12/31/200
XII.	1. Name of F 2. Does the f	nd Fixed Equi Party Holding	ipment (See instructions.) Lease: y real estate taxes in addi		ount shown below on	n line 7, column 4?	□NO				
		1 Year Constructe	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option	*			
4	Original Building: Additions	_		\$				3 Begi 4 Endi	ective dates of current nning ng	rental agreer	nent:
5 6 7	TOTAL			\$					nt to be paid in future tal agreement:	years under t	he current
	This amou	unt was calcul igth of the leas	ortization of lease expense ated by dividing the total se		ortized	*		12. 13 14	/2001 /2002 /2003	Annual Re	ent
	15. Îs Moval	ole equipment	ransportation and Fixed rental included in buildin wable equipment:		nstructions.) Description:	YES	NO	akdown of movable eq	winment)		
	C. Vehicle Re	ental (See insti	ructions.)			(Attach a school	die detailing the brea	akuowii oi iiiovabie eq	шршене)		
	1 Use		2 Model Year and Make		3 thly Lease nyment	4 Rental Expen for this Perio		* If	there is an option to l	ouy the buildi	ng,
17 18 19				\$		\$	17 18 19		lease provide complete chedule.	e details on at	tached
20							20	** <u>T</u>	his amount plus any a	mortization o	f lease
21	TOTAL			\$		\$	21	<u>ex</u>	pense must agree wit	h page 4, line	34.

				S	STATE OF ILLI	NOIS						Page 15
	me & ID Number	St Paul's Home				#	0013920	Report Per	iod Beginning:	01/01/2000	Ending:	12/31/2000
XIII. EXP	ENSES RELATING TO N	URSE AIDE TRAINING	3 PROGRAMS (See in	structions.)								
A. T	YPE OF TRAINING PROC	GRAM (If aides are train	ned in another facility	program, attach a	schedule listing	the facility	name, addre	ss and cost per	r aide trained in t	hat facility.)		
	1. HAVE YOU TRAINED DURING THIS REPO		YES 2.	. CLASSROOM	PORTION:			3.	CLINICAL PO	ORTION:	_	
	PERIOD?	K1	X NO	IN-HOUSE PR	ROGRAM				IN-HOUSE PR	ROGRAM		
	If "leas" along comple	4. 4h		IN OTHER FA	CILITY				IN OTHER FA	CILITY		
	If "yes", please comple of this schedule. If "no	', provide an		COMMUNITY	COLLEGE				HOURS PER	AIDE		
	explanation as to why t not necessary.	his training was		HOURS PER A	AIDE							
В. Е.	KPENSES							C. CO	ONTRACTUAL I	NCOME		
			ALLOCATI	ON OF COSTS	(d)					1.1		
			1	2	3		4		In the box belo facility received			
			Fa Fa	cility			-	_	racinty received	u training alue	s ii oiii otiic	i iacinues.
			Drop-outs	Completed	Contract		Total		S			
1	Community College Tuitio	n	\$	\$	\$	\$			4		4	
	Books and Supplies							D. NU	MBER OF AIDE	ES TRAINED		
3	Classroom Wages	(a)										
	Clinical Wages	(b)							COMPLE			
	In-House Trainer Wages	(c)						_	1. From this fa			
6	Transportation		1	1					2 From other	facilities (f)		

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.

(e)

7 Contractual Payments

TOTALS

8 Nurse Aide Competency Tests

SUM OF line 9, col. 1 and 2

(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

(e) The total amount of Drop-out and Completed Costs for

DROP-OUTS

2. From other facilities (f)
TOTAL TRAINED

1. From this facility

your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number St Paul's Home # 0013920

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
		Schedule V	Staff		Outside	e Practitioner	Supplies			
	Service	Line & Column	Units of	Cost	(other th	an consultant)	(Actual or)	Total Units	Total Cost	
		Reference	Service		Units	Cost	Allocated)	(Column 2 + 4)	(Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a 3	hrs	\$	12	\$ 322	\$	12	\$ 322	1
	Licensed Speech and Language									
2	Development Therapist	10a3	hrs		14	413		14	413	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a3	hrs		279	7,225		279	7,225	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
			# of							
9	Pharmacy		prescrpts							9
	Psychological Services									
	(Evaluation and Diagnosis/									
10	Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$	305	\$ 7,960	\$	305	\$ 7,960	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

XV. BALANCE SHEET - Unrestricted Operating Fund.

This report must be completed even if financial statements are attached.

| 1 | 2 | After

		1	Operating		2 After Consolidation*	
	A. Current Assets		- pg			
1	Cash on Hand and in Banks	\$	225,684	\$	247,608	1
2	Cash-Patient Deposits		5,090		7,775	2
	Accounts & Short-Term Notes Receivable-		<u> </u>		<u> </u>	
3	Patients (less allowance)		353,813		367,782	3
4	Supply Inventory (priced at cost)		21,942		26,712	4
5	Short-Term Investments		7,332		15,366	5
6	Prepaid Insurance		1,793		2,391	6
7	Other Prepaid Expenses		2,949		2,949	7
8	Accounts Receivable (owners or related parties)					8
9	Other(specify): Due from Nursing Facility				77,008	9
	TOTAL Current Assets					
10	(sum of lines 1 thru 9)	\$	618,603	\$	747,591	10
	B. Long-Term Assets					
11	Long-Term Notes Receivable					11
12	Long-Term Investments				957,276	12
13	Land		22,696		254,045	13
14	Buildings, at Historical Cost		3,403,152		8,554,542	14
15	Leasehold Improvements, at Historical Cost					15
16	Equipment, at Historical Cost		1,482,000		1,775,553	16
17	Accumulated Depreciation (book methods)		(3,287,580)		(5,024,109)	17
18	Deferred Charges		1,894		15,321	18
19	Organization & Pre-Operating Costs					19
	Accumulated Amortization -					
20	Organization & Pre-Operating Costs					20
21	Restricted Funds		·		·	21
22	Other Long-Term Assets (spe Work in Progress		955		3,241	22
23	Other(specify): Inv. in Senior Care Network)		108,500		108,500	23
	TOTAL Long-Term Assets					
24	(sum of lines 11 thru 23)	\$	1,731,617	\$	6,644,369	24
	TOTAL ASSETS			1.		
25	(sum of lines 10 and 24)	\$	2,350,220	\$	7,391,960	25

		1	perating	2 After onsolidation*	
	C. Current Liabilities				
26	Accounts Payable	\$	115,973	\$ 152,936	26
27	Officer's Accounts Payable				27
28	Accounts Payable-Patient Deposits		5,017	90,892	28
29	Short-Term Notes Payable		17,142	112,601	29
30	Accrued Salaries Payable		110,610	122,884	30
	Accrued Taxes Payable				
31	(excluding real estate taxes)		11,555	11,555	31
32	Accrued Real Estate Taxes(Sch.IX-B)				32
33	Accrued Interest Payable		3,686	3,983	33
34	Deferred Compensation				34
35	Federal and State Income Taxes				35
	Other Current Liabilities(specify):				
	Line of Credit		175,000	175,000	36
37	Due to St. Paul's Foundation		65,508	77,008	37
	TOTAL Current Liabilities				
38	(sum of lines 26 thru 37)	\$	504,491	\$ 746,859	38
	D. Long-Term Liabilities				
39	Long-Term Notes Payable		619,002	3,703,918	39
40	Mortgage Payable				40
41	Bonds Payable				41
42	Deferred Compensation				42
	Other Long-Term Liabilities(specify):				
43					43
44					44
	TOTAL Long-Term Liabilities				
45	(sum of lines 39 thru 44)	\$	619,002	\$ 3,703,918	45
	TOTAL LIABILITIES				
46	(sum of lines 38 and 45)	\$	1,123,493	\$ 4,450,777	46
	,				
47	TOTAL EQUITY(page 18, line 24)	\$	1,226,727	\$ 2,941,183	47
	TOTAL LIABILITIES AND EQUITY				
48	(sum of lines 46 and 47)	\$	2,350,220	\$ 7,391,960	48

01/01/2000

Ending:

Page 17 12/31/2000

^{*(}See instructions.)

0013920

Report Period Beginning: 01/01/2000

Page 18 Ending: 12/31/2000

JF CE	IANGES IN EQUITY	_	1	
			1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$	3,124,342	1
2	Restatements (describe):			2
3				3
4				4
5				5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$	3,124,342	6
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)		(111,916)	7
8	Aquisitions of Pooled Companies			8
9	Proceeds from Sale of Stock			9
10	Stock Options Exercised			10
11	Contributions and Grants		73,136	11
12	Expenditures for Specific Purposes			12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment			14
15	Other (describe) See attachment		(144,379)	15
16	Other (describe)			16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$	(183,159)	17
	B. Transfers (Itemize):			
18				18
19				19
20				20
21				21
22				22
23	TOTAL Transfers (sum of lines 18-22)	\$		23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$	2,941,183	24

^{*} This must agree with page 17, line 47.

Report Period Beginning: 01/01/2000 **Ending:**

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached. Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue		Amount	
	A. Inpatient Care			
1	Gross Revenue All Levels of Care	\$	4,090,524	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$	4,090,524	3
	B. Ancillary Revenue			
4	Day Care			4
5	Other Care for Outpatients			5
6	Therapy			6
7	Oxygen			7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$		8
	C. Other Operating Revenue			
9	Payments for Education			9
10	Other Government Grants			10
11	Nurses Aide Training Reimbursements			11
12	Gift and Coffee Shop			12
13	Barber and Beauty Care			13
14	Non-Patient Meals			14
15	Telephone, Television and Radio			15
16	Rental of Facility Space			16
17	Sale of Drugs			17
18	Sale of Supplies to Non-Patients			18
19	Laboratory			19
20	Radiology and X-Ray			20
21	Other Medical Services			21
22	Laundry			22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$		23
	D. Non-Operating Revenue			
24	Contributions		200,000	24
25	Interest and Other Investment Income***		36	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	200,036	26
	E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)			27
28	See attachment		13,193	28
28a				28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	13,193	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$	4,303,753	30

			2	
	Expenses		Amount	
	A. Operating Expenses			
31	General Services		1,314,717	31
32	Health Care		1,724,010	32
33	General Administration		1,040,614	33
	B. Capital Expense			
34	Ownership		260,803	34
	C. Ancillary Expense			
35	Special Cost Centers		13,487	35
36	Provider Participation Fee		62,038	36
	D. Other Expenses (specify):			
37				37
38				38
39				39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	s	4,415,669	40
-10	TOTAL EXTENSES (sum of fines 51 tin ti 57)	Ψ	4,413,007	70
41	Income before Income Taxes (line 30 minus line 40)**		(111,916)	41
42	Income Taxes			42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$	(111,916)	43

*	This must agree	with page 4,	line 45,	column 4.
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12/31/2000

Does this agree with taxable income (loss) per Federal Income N/A If not, please attach a reconciliation. Tax Return?

^{***} See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

^{****}Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number St Paul's Home

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

1 2** _____ 3

		1	2**	3	4	
		# of Hrs.	# of Hrs.	Reporting Period	Average	
		Actually	Paid and	Total Salaries,	Hourly	
		Worked	Accrued	Wages	Wage	
1	Director of Nursing	1,826	2,335	\$ 49,342	\$ 21.13	1
2	Assistant Director of Nursing	1,848	2,312	43,740	18.92	2
3	Registered Nurses	10,614	11,733	186,320	15.88	3
4	Licensed Practical Nurses	25,707	28,227	382,820	13.56	4
5	Nurse Aides & Orderlies	77,756	84,005	722,460	8.60	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,398	7,074	65,748	9.29	8
9	Activity Director	1,648	1,838	19,534	10.63	9
10	Activity Assistants	5,727	6,007	38,103	6.34	10
	Social Service Workers	4,780	5,114	51,721	10.11	11
12	Dietician					12
13	Food Service Supervisor	2,448	2,618	37,361	14.27	13
14	Head Cook	1,625	1,771	17,172	9.70	14
15	Cook Helpers/Assistants	10,282	11,685	84,522	7.23	15
16	Dishwashers	18,962	20,030	129,679	6.47	16
17	Maintenance Workers	9,631	10,489	78,734	7.51	17
	Housekeepers	28,963	32,020	229,168	7.16	18
19	Laundry	15,962	17,641	119,486	6.77	19
20	Administrator	2,516	2,724	74,608	27.39	20
21	Assistant Administrator					21
22	Other Administrative	2,249	2,485	45,534	18.32	22
23	Office Manager	2,131	2,386	39,017	16.35	23
24	Clerical	13,429	14,528	110,196	7.59	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
	Other Health Care(specify)					32
	Other(specify) Van driver/secur.	2,234	2,555	17,716	6.93	33
	TOTAL (lines 1 - 33)	246,736	269,577	s 2,542,981 *	\$ 9.43	34

^{*} This total must agree with page 4, column 1, line 45.

B. CONSULTANT SERVICES

		1	2	3	
		Number	Total Consultant	Schedule V	
		of Hrs.	Cost for	Line &	
		Paid &	Reporting	Column	
		Accrued	Period	Reference	
35	Dietary Consultant	151	\$ 6,670	Line 1 col 3	35
36	Medical Director	as needed	6,000	Line 9 col 3	36
37	Medical Records Consultant	12	345	Line 10 col 3	37
38	Nurse Consultant	1	50	Line 10 col 3	38
39	Pharmacist Consultant	32	200	Line 10 col 3	39
40	Physical Therapy Consultant	279	7,225	Line 10 col 3	40
41	Occupational Therapy Consultant	12	322	Line 10 col 3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	14	413	Line 10 col 3	43
44	Activity Consultant	66	3,222	Line 11 col 3	44
45	Social Service Consultant	16	779	Line 12 col3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	583	s 25,226		49

C. CONTRACT NURSES

51 Licensed Practical Nurses 52 Nurse Aides 7,688 121,083 Line 10 col 3			1	2	3	
Paid & Contract Wages Column Reference 50 Registered Nurses S 51 Licensed Practical Nurses 52 Nurse Aides 7,688 121,083 Line 10 col 3			Number		Schedule V	
Accrued Wages Reference 50 Registered Nurses S 51 Licensed Practical Nurses 52 Nurse Aides 7,688 121,083 Line 10 col 3			of Hrs.	Total	Line &	
50 Registered Nurses S			Paid &	Contract	Column	
51 Licensed Practical Nurses 52 Nurse Aides 7,688 121,083 Line 10 col 3			Accrued	Wages	Reference	
52 Nurse Aides 7,688 121,083 Line 10 col 3	50	Registered Nurses		\$		50
	51	Licensed Practical Nurses				51
	52	Nurse Aides	7,688	121,083	Line 10 col 3	52
53 TOTAL (lines 50 - 52) 7,688 \$ 121,083	53	TOTAL (lines 50 - 52)	7,688	\$ 121,083		53

^{**} See instructions.

STATE OF ILLINOIS

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0013020 Percent Percent

	St Paul's Home			# 0013920		Report 1	Period Begin	ning: 01/01/2000	Ending: 12/31/2000
XIX. SUPPORT SCHEDULES									
A. Administrative Salaries		Ownership		D. Employee Benefits and Payro				Dues, Fees, Subscriptions and	
Name	Function	%	Amount	Descriptio			nount	Description	Amount
Arthur H. Peters	President/Administrator	0	\$ 74,608	Workers' Compensation Insura				PH License Fee	
				Unemployment Compensation I	nsurance			vertising: Employee Recruitn	
				FICA Taxes				alth Care Worker Backgroun	
				Employee Health Insurance				dicate # of checks performed	<u>69</u>)
				Employee Meals				wspapers and Subscriptions	1,870
				Illinois Municipal Retirement F	und (IMRF)*		Life	e Services Network Trust	5,589
				Employee Relations Expense			5,777 Pro	motion and Advertising	5,000
TOTAL (agree to Schedule V, line	e 17, col. 1)						Me	mbership fees in Long Term (Care
(List each licensed administrator s	separately.)		\$ 74,608				Org	ganizations	165
B. Administrative - Other								<u> </u>	
							Le	ss: Public Relations Expense	()
Description			Amount					Non-allowable advertising	(2,156)
•			\$					Yellow page advertising	(2,844)
		_		TOTAL (agree to Schedule V,		\$ 60	02,914	TOTAL (agree to Sc	h. V, \$ 20,953
		_		line 22, col.8)				line 20, col. 8	8)
TOTAL (agree to Schedule V, line	e 17, col. 3)	_	\$	E. Schedule of Non-Cash Comp	ensation Paid		G.	Schedule of Travel and Semin	nar**
(Attach a copy of any managemen	t service agreement)			to Owners or Employees					
C. Professional Services	,			7				Description	Amount
Vendor/Payee	Type		Amount	Description	Line#	An	nount	r	
Automatic Data Processing	Payroll services		\$ 8,441	r		\$	Ou	t-of-State Travel	S
Thompson Coburn	legal services		14,691		<u> </u>				
Greensfelder, Hemker and Gale	legal services		8,156	-	-				
Rice, Sullivan and Co., Ltd.	audit services		5,553	-	-		In-	State Travel	
Tuee, sum van und een, Eeu	dadie services				_			2000 110,01	1,326
									1,020
									
							So	minar Expense	
					-			mmai Expense	3,865
			-		_				3,003
					= -			44. E	
TOTAL (agree to Schedule V, line	10 solumn 2)			TOTAL		e.	En	tertainment Expense	()
/	,	`	c 26 941	TOTAL		a		(agree to Sch. V	,
(If total legal fees exceed \$2500 att	tach copy of invoices.	.)	\$ 36,841				10	TAL line 24, col. 8)	\$ 5,191

^{*} Attach copy of IMRF notifications

^{**}See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3). (See instructions.)

	(See instructions.)												
	1	2	3	4	5	6	7	8	9	10	11	12	13
		Month & Year						Amount of	Expense Amor	rtized Per Year	•		
	Improvement	Improvement	Total Cost	Useful	EX.400	FW4000	EV/1000	EX.2000	EX /2004	F71/2002	EN 2002	EX /200 4	EN/2005
	Type	Was Made		Life	FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	Interior Repainting	10/97	\$ 988	36 mo	\$ 81	\$ 324	\$ 324	\$ 259	\$	\$	\$	\$	\$
2	Interior Repainting	3/97	15,077	36 mo	3,780	5,040	5,040	1,217					
3	Interior Repainting	4/98	1,720	36 mo		432	576	576	136				
4	Interior Repainting	10/98	763	36 mo		63	252	252	196				
5	Interior Repainting	10/98	2,832	36 mo		237	948	948	699				
6	Interior Repainting	12/98	560	36 mo		16	192	192	160				
7	Interior Repainting	01/99	130	36 mo			48	48	34				
8	Interior Repainting	01/99	360	36 mo			120	120	120				
9	Interior Repainting	01/99	540	36 mo			180	180	180				
10	Interior Repainting	04/00	134	36 mo				36	48	50			
11	Interior Repainting	09/00	172	36 mo				20	60	60	32		
12	Interior Repainting	09/00	135	36 mo				16	48	48	23		
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 23,411		\$ 3,861	\$ 6,112	\$ 7,680	\$ 3,864	\$ 1,681	s 158	\$ 55	s	\$

	y Name & ID Number St Paul's Home	#	0013920	Report Period Beginning:	01/01/2000	Ending:	12/31/2000
XX. G	ENERAL INFORMATION:						
(1)	Are nursing employees (RN,LPN,NA) represented by a union?	(13)		upplies and services which are of the Public Aid, in addition to the daily in			
(2)	Are there any dues to nursing home associations included on the cost report? Yes If YES, give association name and amount. Life Services Network Trust \$5589		in the Ancillary Sec	etion of Schedule V? Yes	_		
(3)	Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report?	(14)	the patient census l is a portion of the b	ouilding used for any function other isted on page 2, Section B? No uilding used for rental, a pharmacy explains how all related costs were a	, day care, etc.)	For example If YES, attac	e,
(4)	Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity?	(15)	Indicate the cost of on Schedule V. related costs?		assified to employ meal income be the amount. \$		ainst
(5)	Have you properly capitalized all major repairs and equipment purchases? What was the average life used for new equipment added during this period? Yes 15	(16)	Travel and Transpo	rtation acluded for out-of-state travel?	No		
(6)	Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 5,367 Line 10		If YES, attach a	complete explanation. parate contract with the Departmer	nt to provide med		
(7)	Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.		program during to. What percent of	his reporting period. \$ all travel expense relates to transpoge logs been maintained? No			
(8)	Are you presently operating under a sale and leaseback arrangement? If YES, give effective date of lease.		e. Are all vehicles s times when not i	stored at the nursing home during th	_		
(9)	Are you presently operating under a sublease agreement? YES X NO		out of the cost re		v		No
(10)	Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.		Indicate the ar	nount of income earned from plusting this reporting period.			
		(17)		performed by an independent certifice Sullivan and Co., Ltd.	ed public accour	nting firm? The instruct	
(11)	Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 62,038 This amount is to be recorded on line 42 of Schedule V.			hat a copy of this audit be included	with the cost re	port. Has thi	s copy
(12)	Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? Yes If YES, attach an explanation of the allocation.	(18)	Have all costs which out of Schedule V?	h do not relate to the provision of le	ong term care be	en adjusted o	out
	<u> </u>	(19)	performed been atta	e in excess of \$2500, have legal invached to this cost report? Yes a summary of services for all arch		•	ices

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